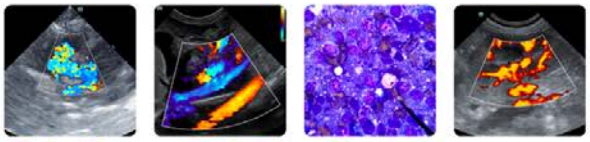


PATIENT

Daisy Wilcox

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

3.77 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Conrad Weiser Animal Hospital

REFERRING VET

Gina Watzka, DMV

INVOICE

72253

DATE

12/2/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate weight loss, chronic vomiting, and elevated liver enzymes. Patient has a history of chronic vomiting; now has lost about 1 pound of body weight. PE shows jaundice but otherwise was fairly unremarkable. Littermate has presumptive IBD (diagnosed about 1 year ago) and has responded well to prednisolone. Rx on Abx and Prednisolone last week but unsure if actually receiving meds due to difficulty with med administration. Meds: Clavamox suspension 1mg PO Q12h, Veraflox suspension 1ml PO Q12h, Prednisolone 5mg daily AUS- reactive to probe pressure over left panc area as well as subxiphoid pressure

Abnormal PE/Chem/CBC/UA Results: - CBC***: Hct - 30% L (31-51), WBC - 25,600 H (3,900 - 19,000), LYMPH - 10,946 (H), Mono - 1,024 (H), Plts - 77,000 (moderate platelet clumping observed) ****clot noted in tube at lab - CHEM - ALT - 773 H (27-158), ALKP - 304 H (12-59), GGT - 13 H (0-6), - - Tbili - 3.2 H (0-0.3) - UA - USG - 1.022, trace protein, 2+ bilirubin - T4 - 2.6 (normal)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 4.18 cm. Right kidney measured 4.42 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.50 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.30 cm at cranial pole and 0.20 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

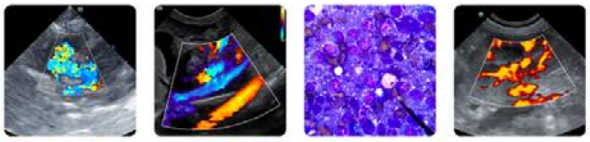
Spleen

Spleen is at the upper end of normal limits for thickness (1.0 cm thick) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- The liver changes are non-specific but could represent a benign hepatopathy such as bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, other infectious or reactive hepatopathy, hepatic lipidosis, although infiltrative neoplasia such as round cell neoplasia i.e., lymphoma can't be ruled out without tissue sampling.
- Mild splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mild or emerging acute pancreatitis, potentially an acute on chronic low-grade smoldering pancreatitis flare up is suspected.

SECONDARY FINDINGS

- Age related kidney changes

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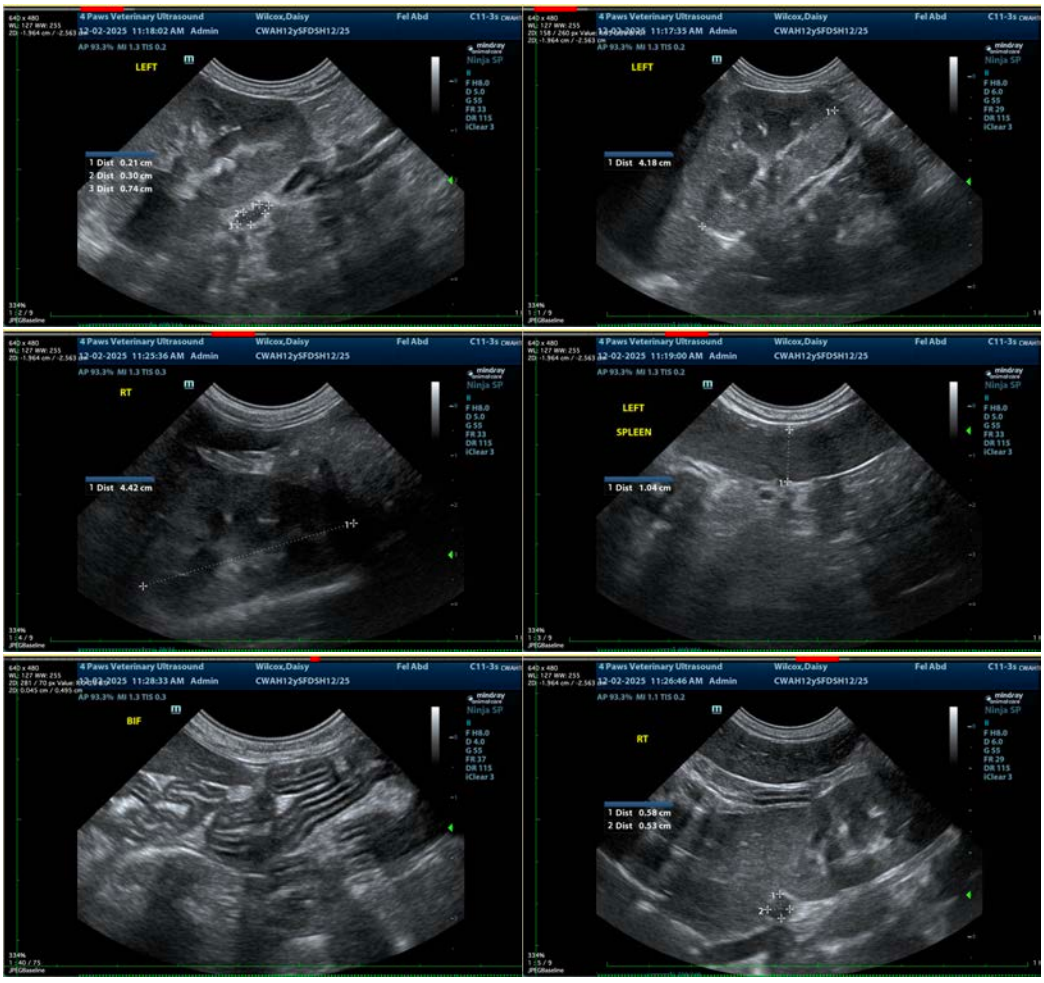
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Fine needle aspirates of the liver and spleen could be considered if patient's coagulation status is appropriate.

Ultimately, however, biopsies of the GI tract, being sure to include ileum, if possible +/- biopsies of the liver may be necessary for definitive diagnosis and therefore to further guide medical management.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support (including a feeding tube) as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



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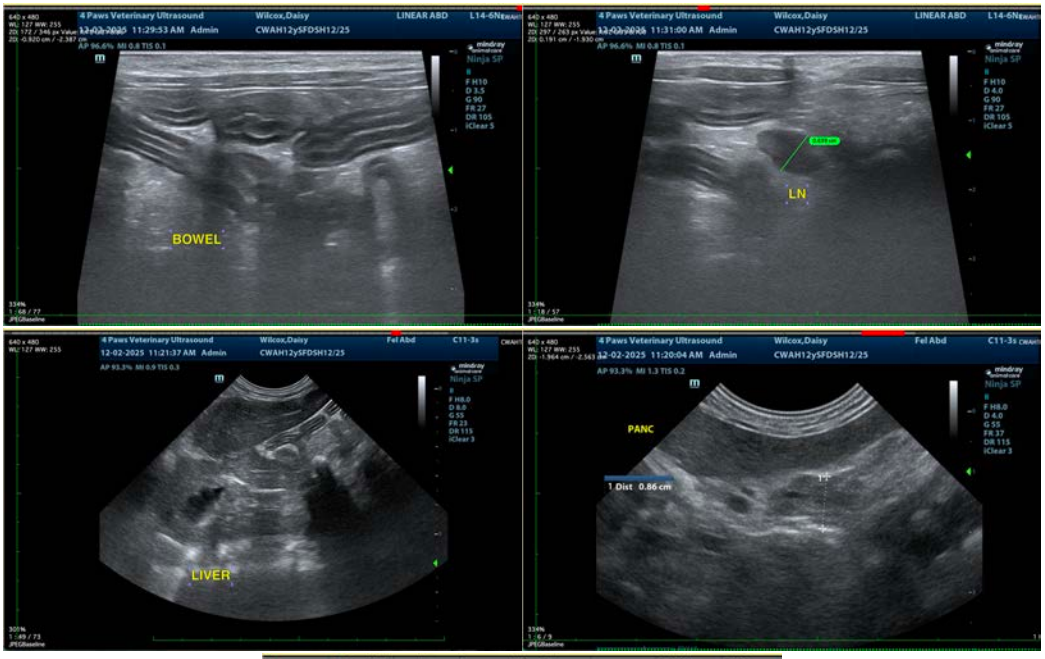

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
info@sonopath.com